STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 87477-001**

v

Aetna Life Insurance Company
Respondent
_____/

Issued and entered
This 27th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 1, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on April 8, 2008.

The Commissioner notified Aetna Life Insurance Company (Aetna) of the external review and requested the information used in making its adverse determination. Information was received on April 16, 2008, from Aetna.

The case presented a medical question so the Commissioner assigned it to an independent review organization, which provided its analysis to the Commissioner on April 22, 2008.

II
FACTUAL BACKGROUND

The Petitioner purchased the "Individual Advantage" health insurance plan from Aetna which became effective March, 2, 2007. On June 27 and June 28, 2007, he received services at the XXXXX, an out-of-network provider.

Claims for those services were filed under CPT codes 96116 (neurobehavioral status examination), 95957 (digital analysis of electroencephalogram), 90801 (psychiatric diagnostic interview examination), and 90887 (interpretation or explanation of results of psychiatric examination). After initially denying these services, Aetna eventually agreed to pay for them at the out-of-network benefit rate.

Aetna denied coverage for the biofeedback treatment (CPT code 90901) provided the Petitioner at PNP since it considers it experimental or investigational for treatment of his condition. It also denied coverage for CPT codes 99199 (unlisted service code) and 90889 (preparation of report).

Aetna terminated the Petitioner's coverage effective December 14, 2007, because he had moved to XXXXX and his Individual Advantage coverage is not available to residents of that state. Along with his appeal of Aetna's denial of his treatment at XXXXX, he also requested that Aetna return the premium he paid for the period from July 15, 2007, when he moved to XXXXX, until his coverage was terminated on December 14, 2007. Since PRIRA only deals with denial of health care services, this order cannot resolve the issue of the Petitioner's request for a refund of premium with the termination of the policy or the proper amount paid for the coverage.

Aetna reviewed the June 27 and 28, 2007, claims for services at XXXXX. It upheld the denial of the biofeedback treatment and the CPT code 90889 preparation of report. A final adverse determination was issued dated February 15, 2008.

III
ISSUE

Is Aetna correct in denying coverage for some of the Petitioner's care at XXXXX provided on June 27 and June 28, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that before he purchased his individual coverage he contacted a number

of health care carriers to determine which coverage best met his needs. He spoke to an Aetna representative who asked for the diagnostic and procedure codes that were to be used in the Petitioner's two-day evaluation at XXXXX to determine if they were covered. After receiving this information Aetna informed the Petitioner that if he chose one of the PPO plans his care would be covered at 50% after the deductible was met, since XXXXX was an out of network facility. (It would have been covered at 80% if XXXXX was a network provider.)

Since the Petitioner anticipated that he might be moving to XXXXX he also asked if that would affect his coverage. He says Aetna indicated it would not because it is a nationwide company. Given this information the Petitioner applied for an individual Aetna PPO plan.

The Petitioner argues that since Aetna led him to believe that his care at XXXXX would be covered, it is required to reimburse him 50% of the $7,200 he was required to pay for the care at XXXXX. He also believes that follow up studies should be covered since any new coverage would include exclusions for pre-existing conditions.

Aetna Life Insurance Company's Argument

Aetna asserts that the Petitioner's claims were processed according to the terms of his policy. The Aetna Advantage PPO Health Plan Summary Description for Michigan includes the following under the sections entitled "Exclusions":

> **Investigational**:
>
> - Any medical, surgical and/or other procedures, services, products, drugs or devices (including Implants): (a) which do not have final approval from the appropriate governmental regulatory body (but see exception under the definition of "Investigational Experimental procedures" in the Glossary); or (b) which are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug , device on health outcomes ;or (c) which do not improve the health outcome of the patient treated; or (d) which are not beneficial as any established alternative; or (e) whose results outside the investigational setting cannot be demonstrated or duplicated; (f) which are not generally approved or used by physicians in the medical community. Aetna has the sole discretion to make this determination.

Aetna considers biofeedback as investigational for Petitioner's diagnosis because there is insufficient evidence in the medical literature documenting the effectiveness of this approach for

many conditions. Aetna concluded that the services billed under CPT code 99199 were biofeedback and therefore not a covered benefit. Aetna also denied CPT code 90889 (preparation of report) as a duplication of services because CPT code 96150 (assessment of findings) had also been billed.

Aetna argues that once it pays for CPT codes 96116, 95957, 90801 and 90887, it will have paid the proper amount for the care provided the Petitioner at XXXXX.

Commissioner's Review

The Petitioner does not dispute Aetna's processing of the claims that it did pay. His complaint is that Aetna should also have covered the services related to biofeedback that were denied because Aetna contends biofeedback is investigational and excluded from coverage.

The Petitioner's policy says that investigational services are not covered. In reviewing adverse determinations that involve issues of whether a service is investigational or experimental, the Commissioner requests an analysis and recommendation from an independent review organization (IRO). The IRO expert reviewing this case is a licensed physician with a certification in psychiatry and neurology.

The IRO reviewer noted that the Petitioner's is a 31-year-old male who referred himself to XXXXX for assessment, apparently because he was having difficulties with memory, mental organization, lack of focus, and making decisions. There was no statement in the medical records why the provider or the patient specifically requested biofeedback treatment.

The IRO reviewer noted that Aetna covers biofeedback for "tension headache, migraine, subjective tinnitus, late effects of cerebrovascular disease, Raynaud's syndrome, temporomandibular joint disorders, chronic constipation, irritable bowel syndrome, anal spasm, stress incontinence, female, incontinence of urine, incontinence of feces, and intracranial injury of other and unspecified nature."

The IRO medical expert indicated the standard diagnostic approach of patients presenting with the Petitioner's symptoms (i.e., depression) would include a comprehensive psychiatric history

and mental status examination, neurophysiological testing, and in view of history of head injury, a neurological consultation.

In the professional opinion of the IRO reviewer, biofeedback is an investigational treatment for depression: “It has not been approved by a governmental body, is not supported by objective scientific evidence, and is not used in the treatment of depression.”

The Commissioner is not required in all instances to accept the IRO’s recommendation. However, the IRO recommendation is afforded deference by the Commissioner; it is based on extensive expertise and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the findings of the IRO reviewer and finds that the Petitioner’s biofeedback provided by XXXX is investigational for treatment of his condition and is not a covered benefit.

The Commissioner also finds that CPT code 90889 (preparation of report) is included in the payment of CPT code 96150 (assessment of findings) which was paid by Aetna. Therefore no additional payment is due under CPT code 90889.

Finally, the Petitioner contends that Aetna misinformed him that all his care at XXXXX would be a covered benefit. Aetna does not believe that it misled the Petitioner. Under the Patient’s Right to Independent Review Act (PRIRA), the Commissioner’s role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. The Commissioner cannot resolve a factual dispute like the described by the Petitioner here because the PRIRA process lacks the hearing procedures necessary to make credibility determinations or findings of fact based on oral statements. Moreover, the Commissioner lacks the authority, possessed by the circuit court, to order relief based on doctrines such as estoppel or waiver.

The Commissioner finds that Aetna correctly applied the provisions of the Petitioner’s coverage.

V
ORDER

The Commissioner upholds Aetna Life Insurance Company's adverse determination of February 15, 2008. Aetna is not required to provide coverage for the Petitioner's biofeedback or "preparation of report" charge related to his care at XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

_____

Ken Ross
Commissioner